Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Alfe	**CHAPTER 100.1**
Address: **1464 Puanakau Street, Honolulu, Hawaii 96818**	**Inspection Date: October 8, 2019 Annual**

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** Primary Care Giver (PCG), Substitute Care Giver (SCG) #1, SCG #2 – No documentation of 2 step tuberculosis available for review.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Find/locate the records of the 2 steps for V.B., L.A. & D.T. from previous caregivers files	10/21/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** Primary Care Giver (PCG), Substitute Care Giver (SCG) #1, SCG #2 – No documentation of 2 step tuberculosis available for review.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** 2nd step received and it's in the binder.	10/1/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** Primary Care Giver (PCG), Substitute Care Giver (SCG) #1, SCG #2 – No documentation of 2 step tuberculosis available for review.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will utilize a checklist for annual T.B. clearances & periodically check quarterly noting which one expires & I will have my substitute care-giver double check the checklist.	10/21/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container. **FINDINGS** Resident #1 – • Oxymetazaline hydrochloride 0.05% nasal decongestant spray PRN/nose bleed ordered 10/12/18. MAR indicates discontinued 9/16/19, however, no discontinuation order available for review. • Biascodyl 10mg rectal suppository ordered 10/12/18., MAR indicates discontinued on 9/16/19, however, no discontinuation order available for review.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Order was clarified and it's filed on the Resident's chart.	10/9/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container. **FINDINGS** Resident #1 – • Oxymetazaline hydrochloride 0.05% nasal decongestant spray PRN/nose bleed ordered 10/12/18. MAR indicates discontinued 9/16/19, however, no discontinuation order available for review. • Biascodyl 10mg rectal suppository ordered 10/12/18., MAR indicates discontinued on 9/16/19, however, no discontinuation order available for review.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will have my substitute caregiver double check the Doctor's orders after coming from appointments.	10/9/19

Licensee's/Administrator's Signature: Virginia A. Baptista

Print Name: VIRGINIA A. BAPTISTA

Date: 10/21/19

Licensee's/Administrator's Signature: Virginia A. Baptista

Print Name: VIRGINIA A. BAPTISTA

Date: 11/15/19